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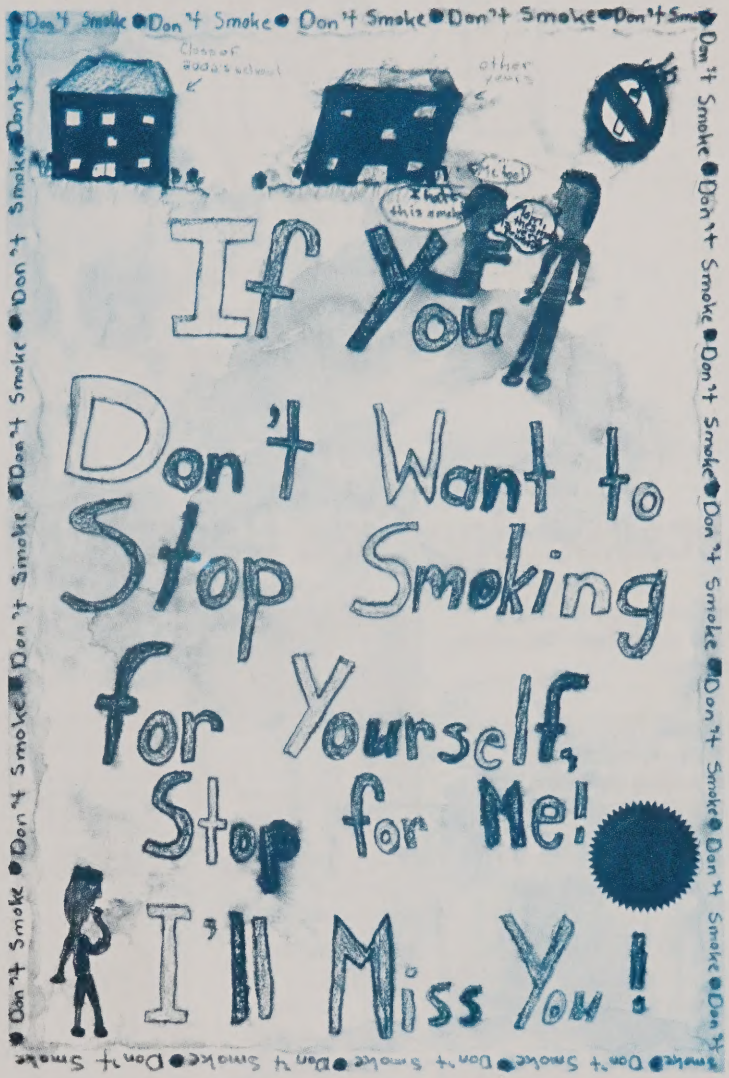

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THE
Hampden Hippocrat
MAY—JUNE 1993

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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From the Editors

Cancer is the second leading cause of death in the United States. 30% of cancer deaths are related to smoking; 30% to diet, and 30% to heredity, ranging from hereditary cancer to hereditary predisposition to cancer such as defects in the ability to repair injured genetic material. The remainder is related to viral infection, radiation, environmental poisons, etc.

During the last twenty years the services available to cancer patients in the valley have grown enormously. State-of-the-art radiation is available; chemotherapy and biologic therapy are available and continuing to expand; the capacity to perform autologous marrow transplantation was recently acquired. Surgical technology rivals that in major cancer centers. We are members of national clinical trials groups. Investigational drugs are as available to our patients as to patients near major centers.

In this issue, contributions from cancer specialists highlight programs and promises for our patients. ■

Brigid Glackin, M.D.
Donald J. Higby, M.D.
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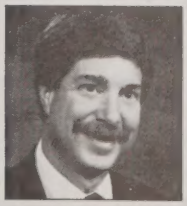
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Hampden Committee Activities

Dr. David Chadbourne, our secretary, reviews recent activities of HDMS committees.

The Nominating Committee met in February. The physicians nominated will be approved by the membership at the April 20th Annual Meeting.

The Medico-Religious Committee met in March. Dr. Michael Rosen, one of our co-speakers for the October 14th Medical Ethics Seminar, outlined proposed areas that could be covered using the topic of Management of the Terminally Ill. These areas consisted of Honesty, Hope, and Ethical Pain Management. However, the main topic will not be finalized until we have the input of our other co-speaker, Dr. Steven Reichert.

The Medico-Legal Committee met in April. The Interprofessional Guidelines, which was formerly the Hampden County Medico-Legal Code, has been reworked and approved by the committee members. It now has to be approved by the Executive Committee before it will be distributed to the membership. The Medico-Legal Educational Seminar has been tentatively scheduled for September 22, 1993. Physician Educational Credits will be applied for. A sub-committee has been formed to work on the details of the program. The committee members felt that a Golf Tournament would not be well attended and that some of the local country clubs wanted a large group. It was suggested that a small group of lawyers and physicians that already belong to a country club, could get together before the educational seminar and play. Attorney William Fitzgerald and Dr. Mark Mullan will look into this.

The Public Health Committee has written a second article for their media compaign. It dealth with the topic of rabies. Dr. Edward Galaid, who composed the article was interviewed by WARE radio station. The Committee is now discussing ways in which they can work with the Springfield School Volunteers. Dr. Alonzo Sheffield, a member of our Public Health Committee, is already helping by agreeing to be the speaker for the I-Loop Educational Program that our Health Care Task Force Committee is working on.

The Executive Committee met in February, March and April. Dr. Horrigan attended the AMA Leadership Conference in February and reported that the thrust of the conference was to state that the medical community is the group that is best qualified to assist in health care reform.

Dr. Molly Noonan, the Medical Director of Western Mass. Hospital, approached our Committee on the proposed closing of the hospital. She asked for a letter of support from Hampden District Medical Society. Letters were sent to Governor Weld and our Area Legislators.

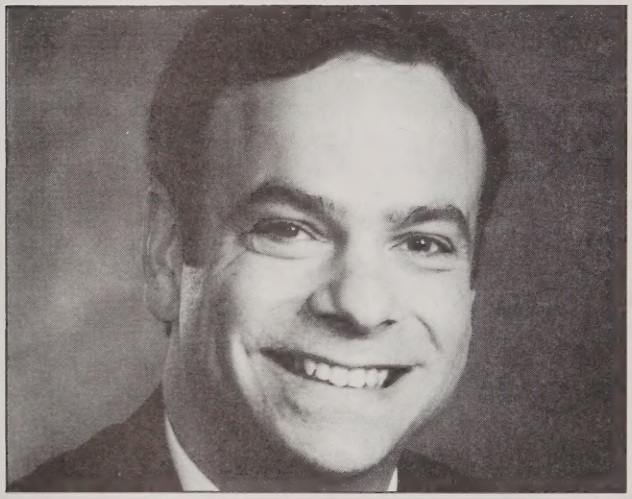
Dr. Chircop attended the MMS Task Force Retreat. He reported that recommendations would be made to the MMS Council at the March 31st Special Council Meeting. This includes adopting a House of Delegates Structure similar to the AMA. Also there would be a Board of Trustees comprised of members elected by the districts.

Dr. Dress reported that the Legislative Breakfast will be held on April 30th at Mercy Hospital's Deliso Center. The topics will be Child Protection and the Report of the Special Commission on Nursing Shortages.

Ms. Barnes reported that our 3rd Annual Poster Constest, which includes all of Hampden and Hampshire Counties, is going well. She stated that 80% of the cities and towns are participating. The judging will be held on May 3rd and the Awards Ceremony will be held at Springfield Symphony Hall on May 12th. The House Calls Program on Smoking Cessation will be held on April 25th to coincide with the Poster Contest. ■

What Have They Done For Me Lately?

As this presidential year draws to a close, I would like to return to my roots as Membership Chairperson to address the age-old question: "What has HDMS done for me lately?". I find this important at present, because from the answer to the question, the membership can draw its commitment and strength to enter the next presidential year boldly and vigorously.



Robert V. Chircop, M.D., President

HDMS advocates two essential goals: the Public Health and Professional (Member) Health. Each serves the other. In the year now concluding, HDMS has been visibly active in each arena with several programs. In the Public Health arena, our Public Health Committee has once again sponsored a "No Smoking" Poster contest for 3rd grade students, this year at over 50 schools throughout Hampden and Hampshire counties, in conjunction with the Hampshire District Medical Society. The Public Relations Committee sponsored a television "House Calls" program this Spring focusing on smoking issues as well. Our Public Health Committee has produced educational releases for local news media regularly this year, on issues of seasonal importance to the public. The Health Care Access Task Force has met with multiple civic and public leaders over the last year, and now sends members to meet regularly with the Neonatal and Infant Mortality Study Group, and the Springfield Community Neighborhood Health Center Task Force. Production is expected to begin this Spring on a cable-video health education effort with the Putnam High School in Springfield. An unplanned bonus of the HDMS Task Force's activities was that our new-formed relationships with area leaders permitted us to intercede most effectively on behalf of the unique programs and facilities at Western Mass Hospital when its closure was contemplated. HDMS as a whole this year took up the issue of passive tobacco smoke exposure in public eating places as a public health risk, urging area Boards of Health to adopt bans on smoking in restaurants. We have also personally attended area-wide meetings of the Boards of Health to help that process go forward, and results so far are encouraging. The Legislative Committee again this Spring hosted the area Legislators at a breakfast program to lobby for a seatbelt law and several other public health-related bills. The HDMS Education Committee hosted a lecture at the Springfield Museums open to the public early this Spring. The Museum Association is eager to host these more frequently, and our Education Committee might very well expand this into a regular public lecture series that could reach an additional sector of our community.

In the Professional (Member) Health arena, HDMS has been equally active. At our request most area hospitals and managed-care organizations are synchronizing their Privilege Renewal cycles for physicians beginning this June, so that physicians can conveniently satisfy those obligations concurrently. Medical Directors,

Department Chairs and personnel should also find this system efficient and cost effective. The HDMS Legislative Committee is lobbying area State Legislators on bills concerning HIV/AIDS reporting, Health Care Worker disability, Tort Reform, HMO contract issues, and a particularly ill-conceived Nurse Practitioner Bill. The Medico-Legal Committee has worked out, jointly with the Hampden County Bar Association, formats for Attorneys and Physicians to follow, to facilitate obtaining and providing medical records and reports. These hold great promise in obviating the need for personal appearances in court, removing a great burden to one's practice and schedule. The same Committee produced an educational dinner meeting for physicians and attorneys, which promises to be an annual event, and hopes to produce an annual charity fundraiser such as a golf tournament as well. The Medico-Religious Committee continues to produce annual educational programs each Fall which members can conveniently attend. Topics usually fall within the realm of Medical Ethics, and cut across most lines of medical practice. The HDMS Tax-Supported Medical Care Committee actively participates with the statewide MMS Committee to intercede on our behalf with the Medicaid program, in identifying and solving problems there.

All in all, each member of HDMS should have no difficulty realizing the value of all the District's activities. Being its President for one year has been a unique vantage point from which to witness the many individual contributions to the whole. Answers to the next question, "What hasn't HDMS done for me lately?", can generate an agenda to expand the scope of HDMS further. ■

In Memoriam

Elmer Franseen, M.D., passed away on March 20, 1993. He graduated from Harvard Medical School in 1940, and trained in orthopedics at the Hospital for Crippled Children in Springfield, and at the Massachusetts General Hospital and Boston City Hospital. During his career, he served twelve years as director of orthopedic services at Baystate Medical Center. He served in the U.S. Navy. He leaves his wife, Elizabeth, and a son and daughter. ■

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Medical Oncology: The Next Two Decades

Donald J. Higby, M.D., is the Chief of Hematology/Oncology at Baystate Medical Center.

Although there may be incremental refinements in surgery and radiation therapy in the treatment of cancer, these modalities are fundamentally aimed at regional tumor control. About half the patients who get cancer die of metastatic disease. Thus the control of systemic cancer offers the greatest hope for the future.

"The control of systemic cancer offers the greatest hope for the future."

Chemotherapeutic agents continue to be developed; during the last two years, five new drugs have come on to the market. All chemotherapy drugs are aimed at causing lethal damage to genetic material. They are also relatively non-specific, and *always* cause some degree of damage to normal tissues. The management of side effects from chemotherapy drugs has come a long way. It is now feasible to deliver most chemotherapy in the outpatient setting; the exceptions being infusions of drugs and the use of ultra-high dose regimens. The chances of chemotherapy-related bacterial infections can be greatly lowered with colony-stimulating factors as well as prophylactic antibiotics of the quinolone class. Bone marrow stem cells can be harvested, cryopreserved, and given back to the patient after delivery of a "lethal" dose of chemotherapy—a strategy that has proven curative in lymphomas, leukemia, germ cell tumors, and probably in certain cases of breast cancer. Enhancement of the effects of chemotherapy through alterations in traditional schedules, the use of biochemical modulation of the pharmacology of drugs, etc., are also being explored. In the near term, chemotherapy together with radiation and surgery seem to offer the promise of increased cure in stage III lung cancer, bladder cancer, colorectal cancer, breast cancer, etc. Patient and sometimes tedious exploration of multimodality approaches to cancer will almost certainly pay off in the short run.

Unfortunately, there are certain limitations to chemotherapy that probably cannot be overcome. These include the fact that tumors develop drug resistance relatively easily, and that it is impossible to completely protect the patient from toxicity while still allowing the drugs to act on the tumor.

Biological therapy has been disappointing as well. In the early '70's the advent of interferon heralded a new era in cancer therapy. Since then, several interferons, interleukins, and various other biologic factors have undergone clinical trials. Although these agents occasionally produce remarkable results, in the vast majority of cases the quality and frequency of responses resemble those of chemotherapy—and the biological therapies developed so far also have associated toxicity. Biologic therapies may depend upon the ability of the immune system to recognize cancer cells. Yet, it is highly likely that some clones of almost any malignancy are sufficiently similar to normal tissues so that immunologic recognition is impossible. On the other hand, biologic therapies which directly affect tumor cells would also be expected to affect normal tissues. Thus there seems to be a major limitation to these therapies as well.

We are now entering a new era of promise. As we understand more and more about the molecular genetics of the cancer cell, several inviting targets have revealed themselves.

Cancer cells differ from normal cells because of genetic mutations. Using polymerase chain reactions and other probes, it is increasingly

possible to identify the mutations associated with a given cancer. In fact, some of the mutations seem to turn up over and over again. In addition, we now know how many of the mutations alter the cell machinery to produce cancer. Some act to alter the numbers of membrane receptors for growth and cell division; others alter transport proteins within the cell. Still others have to do with the secretion of peptide hormones which stimulate growth in other tumor cells (paracrine) or even the cells which produce the substances (autocrine). Some genetic mutations are selected out because of exposure to chemotherapy—"multidrug resistance", hypertrophy of enzyme systems which catabolize antimetabolites; even enhancement of enzyme systems which repair DNA.

Altering the genetic code in cancer cells to a more favorable status will be an exciting application of the new biology. For example, it is possible to develop viral vectors which can transport genes into cells. Thus in cancer cells which are missing genes which ultimately regulate growth, the possibility of replacing them exists.

The use of "anti-sense" drugs is also appealing. Essentially these are RNA sequences which can strongly bind to genetic regions on the DNA, preventing transcription of that region. Several anti-sense compounds are being studies in cultures and animal models.

Engineering agents which act as "false messengers" via binding to cell surface receptors in place of the natural small effector molecules is another path of great interest. A prototype agent which has limited usefulness in prostate cancer is suramin, an old antiparasitic drug. In small cell lung cancer, growth of tumor depends upon peptide signals generated by the tumor cells, which then bind to surface receptors on the tumor cells. The development of an agent which competitively inhibits this binding would obviously have clinical application.

For tumors to grow larger than a few millimeters, it is necessary for them to develop a blood supply. The vascularization of tumor tissue occurs in response to signals from tumor to local blood vessels, which then sprout capillaries which invade the tumor. Angiogenesis factors are mediators of this event. It may be possible to down-regulate the production of these hormone-like substances, or to block membrane receptors to the effects of these signals, and these events have been achieved in the laboratory.

Continued on next page

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Medical Oncology

Continued from previous page

Preventing angiogenesis would certainly keep tumors at very small sizes; however, we could expect that wound healing would be severely impaired, and perhaps, that over the course of time miliary dissemination of micrometastases would occur anyway, resutling in the death of the host.

One area of great interest has to do with aptosis, or programed cell death. It turns out that even the most wildly undifferentiated cancer cells conserve a genetic program which when switched on, causes the cell to commit suicide. Aptosis, of course, can be triggered by chemotherapy or radiation, but requires the cell to proceed through mitosis. If cells are turning over very slowly, there is ample time for repair of genetic material, so that cell death does not occur.

Aptosis is fairly well understood. The intracellular calcium balance is dynamically controlled by the endoplasmic reticulum. When this control weakens, intracellular calcium rises; at a certain concentration, there is a breakdown in the protein matrix which is responsible for the quaternary structure of the DNA. When the DNA no longer can hold its quaternary structure, it is exposed to intranuclear DNA-ase and other destructive enzymes. The result is the formation of DNA fragments. The cell then degenerates and dies. Certain plant substances have been isolated which act directly on the endoplasmic reticulum, inhibiting the uptake of calcium and triggering aptosis. Specificity is a problem, however, and attempts are being made to bind these substances to monoclonal antibodies, etc.

The imagination, unlike reality, has no limits. Because we live in a society which increasingly has to make choices about how the health care dollar is spent, there are several ominous hints that we may never realize the promise of the new biology. First, it is increasingly difficult to justify (unless of course, you are the patient) spending a great deal of money for the modest gain in the life-span of a cancer patient. It has been arguably shown that in non-small cell lung cancer, chemotherapy does increase survival by several weeks, on the average. In fact, in many cancers, both common and uncommon, survival advantages of a few weeks to a few years have been shown. From a societal perspective, however, the productivity of these patients is way below normal, and frequently they consume not only medical but social resources (disability, etc). Likewise, although hormone resistant metastatic prostate cancer is a major cause of cancer-related death, the vast majority of patients are retired, using social security and medicare benefits, and are "non-productive". Perhaps this is the reason that there is such little attention being paid to this problem, which is a far more common cause of death than HIV infection.

There is no doubt that it would be cheaper simply to consign all patients with incurable cancer to "hospice". It is when we consider rationing of cancer care that numerous dilemmas loom. Should we ration by age? This would be unacceptable to congresspersons, businesspersons, lawyers, physicians, actors, and others who continue to lead productive lives well into their eighties in some cases. Should we ration by outcome? Should the patient with metastatic pancreatic cancer be denied chemotherapy because no one has ever survived this condition? A few patients have had remarkable degrees of palliation, sometimes lasting as long as a year. Is this "worth it"? Should we ration by cost? Should autologous transplants be denied patients with breast cancer because of their expense? At the present time, patients with previously untreated metastatic breast cancer can expect perhaps a 10-15% chance of long-term survival with such a therapeutic approach. Perhaps we could cure as many patients with metastatic breast cancer as we cure leukemics with transplantation technology, where it is an accepted therapy. Given the frequency of lymphoma and the frequency of metastatic breast cancer, even though the chances of cure with the latter are much smaller, the societal impact may be the same in terms of absolute numbers of cures produced.

Perhaps the best way to ration, if ration we must, would be to identify those areas of cancer therapy where available treatment is inadequate. Third parties should agree to fund treatment in these areas only when patients participate in an authorized clinical trial. (Currently there is evolution towards the exact opposite position—third parties are increasingly denying reimbursement to patients treated on clinical trials). If this were the case both the patient and society as a whole would benefit.

The future of medical oncology is unpredictable. If the new findings in cancer biology are allowed to bear fruit, increasing numbers of patients will benefit (and not just cancer patients). But there is an ominous trend in society to simply "give up" in the quest for cure of advanced cancer. Most cancer patients are older; those with advanced cancer usually succumb to the disease within a year or so of diagnosis; and the cancer "lobby" is as a consequence not nearly as well organized or effective as for example, the HIV "lobby". We ignore the continued search for a cure at our own peril, however. ■

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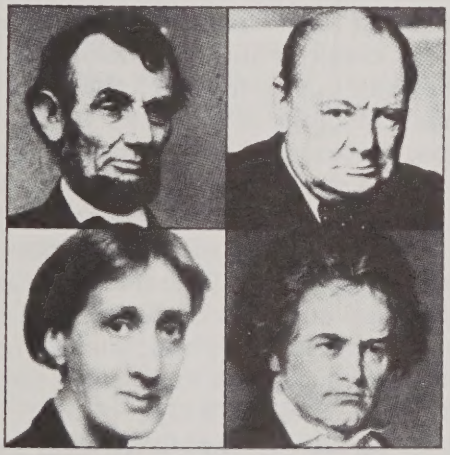

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Gynecologic Oncology In The Pioneer Valley

John L. Powell, M.D., is Chief of Gynecologic Oncology at Baystate Medical Center.

John F. Rampone, M.D. initiated the Gynecologic Oncology program at Baystate Medical Center in 1977. Prior to that time most of the women in Western Massachusetts with genital tract malignancies went to Boston for their care. Subsequent to 1977 that was seldom necessary. Dr. Rampone received his M.D. Degree from Marquette University School of Medicine. He interned at Rhode Island Hospital, completed his OB/Gyn Residency at John Hopkins Medical Center and completed a fellowship in Gynecologic Oncology at Duke University and the Norwegian Radium Hospital in Oslo. Dr. Rampone left Baystate Medical Center in 1984 after providing years of compassionate care to women with cancer and providing excellent teaching to OB/Gyn residents, medical students, and community gynecologists. Dr. Rampone died in December of 1992.

"...a team of nationally and internationally recognized experts"

The Gyn/Oncology Division of the Department of Obstetrics and Gynecology at Baystate Medical Center is currently composed of a team of nationally and internationally recognized experts. This team is lead by John L. Powell, M.D. who has been chief of Gynecologic Oncology since 1984. He is Professor of Obstetrics and Gynecology for Tufts University School of Medicine. He is board certified in Obstetrics and Gynecology, Gynecologic Oncology, and Laser Surgery. Dr. Powell is the author of 50 publications and 5 book chapters. He is the inventor of 3 surgical instruments. He has 21 years of experience in colposcopy and 17 years of experience in laser surgery. He is a board examiner for The American Board of Laser Surgery and has organized and taught laser workshops and seminars since 1977 in the United States, Canada, Europe, Indonesia and China. In addition to The B.S. Degree from Davidson College and The M.D. Degree from the University of North Carolina, Dr. Powell completed his residency in OB/Gyn at Fitzsimons General Hospital in Denver, Colorado and a fellowship in Gynecologic Oncology at the Crawford W. Long Memorial Hospital of Emory University in Atlanta, Georgia.

Michael Prefontaine, M.D. is Associate Professor of Obstetrics and Gynecology at Baystate Medical Center. He graduated from College Lionel Groulx in Montreal, Quebec, Canada and received his medical degree from the University of Montreal. He completed his residency in Obstetrics and Gynecology at Mcgill University in Montreal and fellowships in Gynecologic Oncology at McMaster University in Hamilton, Ontario and at the University of Toronto. He had also been a Galloway fellow at Memorial Sloan-Kettering Cancer Center in New York. He holds certificates of specialization in Obstetrics and Gynecology from the Royal College of Physicians and Surgeons of Canada and the Professional Corporation of Physicians of Quebec. Dr. Prefontaine was Associate Professor of OB/Gyn and Chief of the Division of Gynecologic Oncology at the University of Ottawa for 7 years prior to coming to Baystate Medical Center. He has authored 18 publications at regional, national and international meetings.

Julia T. Donovan, M.D. is Assistant Professor of OB/Gyn at Baystate Medical Center. She received her M.D. Degree from Georgetown University School of Medicine and did an OB/Gyn Residency Training program at the National Naval Medical Center in Bethesda, Maryland. She completed a Gynecologic Oncology fellowship program at the Massachusetts

General Hospital. Dr. Donovan was the Chief of Gynecologic Oncology and Assistant Chief of the Department of OB/Gyn at San Diego Naval Hospital in California prior to coming to Baystate Medical Center 5 years ago. In addition to being a fellow of the American College of OB/Gyn, she is a member of the Association of Women Surgeons. She has participated in local and national meetings with emphasis on problems associated with Gynecologic Oncology and women's health issues.

Barbara Matthews, R.N. had 8 years of experience as a staff nurse in Gynecology prior to becoming the first Gynecologic Oncology Nurse at Baystate Medical Center in 1978. Since then she has served as secretary for the Western Massachusetts Chapter of the Oncology Nursing Society as well as on the Board of Directors for the National Organization of the Society of Gynecologic Nurse Oncologists. She is a co-facilitator of a Cancer Support Group for Women.

Lynette Buley, R.N., O.C.N. had 3 years of experience as a labor and delivery nurse and 6 years of experience as an operating room nurse prior to joining the Gyn/Oncology Division in 1987. She is board certified in Oncology nursing and has served as the chairperson for membership for the Western Massachusetts Chapter of the Oncology Nursing Society. She is currently President-Elect for the Chapter.

Both of the Gynecologic Oncology nurses have lectured at Regional and National Meetings and have been responsible for the development of educational materials used for the education of patients and their families as well as for the nursing student program at Baystate Medical Center. Both have organized and taught at Regional Seminars on Women's Health Care Issues.

During 1992 the Gyn/Oncology service had a total of 2,462 office visits. The Gynecologic Oncologists preformed 216 major and 80 minor operative procedures. There were 146 admissions for inpatient chemotherapy and 56 out patient chemotherapy treatments.

In reviewing the last 8 years of our experience (1984-1992), we have had the following degree of success:

Type of Cancer	# Patients	% Survival
Endometrial	410	85.9%
Cervix	232	72.8%
Ovary	349	74.5%
Vulva	101	78.2%
Uterine Sarcoma	48	66.6%
Vaginal	19	73.7%
Fallopian Tube	2	50.0%
Trophoblastic Disease	54	100.0%
TOTAL	1,215	
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Radiation Therapy for Soft Tissue Sarcomas

Brian Acker, M.D., is Chief of Radiation Oncology at Baystate Medical Center.

Soft tissue sarcomas are not common malignancies: about 5600 cases occur each year in the United States. They are an interesting and important group of tumors, however, because their management illustrates some of the possibilities of tissue conservation or tissue-sparing techniques by the appropriate integration of surgery and radiation therapy. Using modern techniques, many patients who might previously have undergone amputations can now be offered potentially curative treatment while retaining a functional limb. The discussion in this article will focus on soft tissue sarcomas of the extremities where this approach is particularly applicable.

"these tumors illustrate the possibility of tissue sparing by integration of radiation and surgery"

The etiology of the soft tissue sarcomas is still unclear. In rare instances a connection can be drawn between the development of sarcoma and previous exposure to therapeutic radiation. In a small number of cases genetic abnormalities may be present as in the development of neurosarcomas in patients with a history of neurofibromatosis. The cause is unknown in the vast majority of cases.

In general, malignant tumors can spread locally, through lymphatic channels or hematogenously. In the case of sarcomas, local spread is particularly insidious since microscopic disease may extend well beyond the margins of the obvious tumor. Such spread does tend to be along the lines of muscle compartments with much less tendency to transgress from one compartment to another. At the edge of the tumor, growth of the mass often produces compression of the surrounding normal tissue producing a "pseudo-capsule". This is not a true capsule since tumor cells are often present beyond it.

Lymph node spread is relatively uncommon but, unfortunately, blood-borne spread occurs frequently particularly in Grade II or Grade III lesions. The commonest site of metastasis is to the lung with bone and liver metastases much less common.

The pathology of the soft tissue sarcomas appears at first sight to be complex with a multitude of different entities. However, they are grouped by category according to their histologic site of origin so that muscle tissue, for example, gives rise to the leiomyosarcoma (from smooth muscle) and the rhabdomyosarcoma (from striated muscle). Fat gives rise to the different variants of liposarcoma while neural tissue gives origin to the malignant schwannoma, neuroblastoma, etc.

Although some of these malignancies have unique patterns of behavior, in general the differences among the adult soft tissue sarcomas are relatively minor and do not have a major impact on their management. The most important aspect of the pathology in determining management and prognosis is the grade of the tumor. Grade I sarcomas have a 5 year survival of 70% to 90%. The survival for Grade II sarcomas is about 50% while the Grade III lesions have a survival on the order of 25% largely because of their propensity for distant metastasis.

Patients generally present with a history of a slowly enlarging, painless mass. The lesion may grow for months or years before being brought to medical attention and on occasion their innocuous appearance has lead to repeated reassurance from physicians with subsequent medico-legal reprecussions. Upper thigh or

buttocks tumors can grow to a large size before creating symptoms.

Diagnosis is made by surgical biopsy. Fine needle aspiration biopsy can be attempted first but is seldom diagnostic. It is important for the biopsy to be carried out by a surgeon experienced in the diagnosis of sarcoma since careful placement of the initial biopsy incision can have an important impact on subsequent procedures. In general, longitudinal incisions are preferable since they permit a smaller field of radiation therapy treatment should this be necessary. Long radial excisions can create major difficulties for the surgeon doing the ablative procedure and for the radiation oncologist.

Diagnostic work-up should include careful examination of the lesion looking for compromise of neural or vascular structures or bony fixation. CT or MRI scanning of the extremity is essential and if the lesion is adjacent to bone, a bone scan may be helpful. In some instances the surgeon may find angiography helpful. A standard chest x-ray is always done but CT of the chest can detect small metastatic lesions that cannot be seen on the chest x-ray.

High local control rates (80% to 90%) can be obtained through amputation. On the other hand, a "shelling out" procedure frequently leaves microscopic disease behind in the pseudo-capsule and the local recurrence rate is as high as 80%. A number of articles have been published over the past two decades indicating that "tissue-conserving" surgical procedures combined with radiation therapy have been able to provide a very satisfactory level of local control and at the same time avoid amputation.

Surgical procedures used in this context must provide margins that are well clear of the primary tumor thus leaving radiation treatment the task of sterilizing small microscopic deposits of disease. Although there are reports of radiation alone having been used successfully as the sole modality to treat unresectable sarcomas, these lesions are not highly radiosensitive and therefore the doses required are high. For a large lesion this would carry the risk of causing clinically evident fibrosis within the extremity and functional impairment thus defeating the purpose of a conservative tissue-sparing therapy program.

The surgical procedures actually employed depend on the circumstances presented by the particular tumor and range from wide local excision, where the tumor is removed with a margin of several centimeters of normal tissue, to radical excision, where the tumor is removed

Continued on next page

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Soft Tissue Sarcomas

Continued from previous page

en bloc along with the entire muscle compartment. Recurrence rates after wide local excision alone range from 40% to 50% while radical removal of the entire compartment can yield 85% to 90% local control. If surgery is used as the initial treatment, it is helpful once again to locate surgical incisions longitudinally in the extremity and to place surgical clips at the margins of the surgical excision.

Radiation treatment is added to wide excision as a planned procedure to optimize local control. In general, radiation can be given pre-operatively or in the post-operative setting. In some centers a "sandwich" approach has been used giving some of the treatment before and some after the surgical procedure. Selection of the particular approach in a given case depends largely on the preference of the surgeon and radiation oncologist since there are no data available to clearly indicate a superiority of one approach over the other. A high rate of local control is generally obtainable in low grade sarcomas through wide local excision alone, though radiation may be added for close or positive margins.

If pre-operative radiation therapy followed by conservative surgery is the selected approach, a dose level of about 5000 cGy in 5 weeks is used. When radiation treatment is given following surgical resection, somewhat higher doses ranging from 6000 to 6400 cGy are employed since there is less concern regarding possible interference with surgical healing and, on the other hand, a surgical procedure itself can decrease the vascularity of the tumor bed thus rendering it somewhat less sensitive to radiation.

In either case, careful placement of the radiation therapy fields is essential. Prior to treatment, the radiation oncologist must carefully define the anatomic extent of the region at risk and a plan for placement and immobilization of the extremity during the radiation treatment course is developed. The use of modern immobilization devices employing rapidly hardening foam casts has greatly facilitated this process. Care is taken to ensure wide margins around the tumor volume in all directions while at the same time sparing a strip of normal tissue along the length of the treated limb. This is crucial in order to minimize the risk of disabling fibrosis or lymphedema distal to the radiation treatment fields.

When doses higher than 5000 cGy are used, a "shrinking-field" technique is usually employed whereby the initial dose to about 4500 cGy is given to a large field with wide margins and then one or 2 "cone-downs" are carried out reducing the fields for portions of the final treatment. This follows the well known radiobiological principle that smaller concentrations of tumor in the preiphery of the volume at risk can be controlled with high probability using smaller doses then the higher concentrations of tumor within the primary tumor bed itself. This technique allows for the optimization of local control while minimizing the possibility of local tissue complications.

Using these techniques, local control rates ranging from 65% to 90% can be obtained. there is evidence that careful attention to obtaining negative surgical margins at the outset will produce results closer to the higher end of this range. About 25% of patients will develop distant metastasis and therefore the overall five year survival rate is on the order of 75%.

Radiation treatment is, in general, well tolerated acutely with local skin reaction representing the main side-effect along with fatigue and temporary decrease in appetite. Significant complications are uncommon whether the surgical procedure is done before or after radiation treatment. Most series have reported good retention of function following combined modality treatment but loss of range of motion or even the requirement for later amputation can occur on occasion. Careful attention to physical therapy after treatment is important.

What is new on the horizon? Interstitial therapy whereby catheters are placed in the tumor bed and subsequently loaded with radioactive sources to "boost" this area have been beneficial in some circumstances. Investigations are ongoing into the use of multiple treatments per day (hyperfractionation) as well as efforts to enhance the effects of radiation using radiosensitizers. Combining radiation with intra-arterial chemotherapy and the use of particle beam radiation are also being investigated.

Finally, although this article is primarily an outline of the integration of radiation therapy with surgery in the treatment of soft tissue sarcoma, the potential for chemotherapy must be mentioned though its use is controversial. Adjuvant chemotherapy for high-grade sarcomas has fallen into and out of fashion. It clearly has a role to play in the palliative treatment of metastatic disease. It is a cliche to state that "further progress in treating metastatic disease awaits development of improved agents". As the use of increasingly sophisticated combinations of radiation treatment and tissue-sparing surgery produce ever greater degrees of local control, further gains in the treatment of this malignancy will have to come through improved methods of dealing with distant metastasis. ■

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Advances In The Surgical Treatment Of Hepatic Metastases

William P. Reed, M.D., is Director of Surgical Oncology at Baystate Medical Center.

Over the past 15 years, surgical resection has become a recognized method for treating hepatic metastases due to colorectal malignancies. Survival rates as high as 40-50% at 5 years have been reported for the resection of a single focus of metastatic carcinoma confined to a single hepatic lobe and resected with a free margin of at least one centimeter.

"Survival rates as high as 50% follow resection of single hepatic metastases in selected patients."

Initially, surgeons were limited by their understanding of the internal anatomy of the liver to resections of one or the other major hepatic lobe. This resulted in removal of large amounts of normal liver in the treatment of relatively small metastatic foci, a factor that resulted in prolonging the period of recovery, especially in elderly patients, even though regeneration will replace the majority of the resected liver substance over a 3 to 4 week period of time. The need to remove an entire hepatic lobe also precluded resection for those patients whose metastatic lesions set astride the junction between lobes, since removal of both hepatic lobes was not feasible in the absence of transplantation.

Thanks in large part to the French hepatic surgeon Bismuth, who has published extensively in American journals, a clearer picture of the internal hepatic anatomy, as first described by Couinaud, has emerged in recent years. It is now clear that the liver can be divided into eight segments, arranged in pairs to each side and between the spokes formed by the three hepatic veins. By carefully resecting the material between veins, surgeons can now perform segmental resection of metastatic foci, providing adequate margins of resection with removal of much smaller amounts of uninvolved liver. There is a price to pay for this greater precision, however, and these resections tend to be costlier in terms of blood loss. This is because preliminary ligation of the artery and portal vein supplying the segment to be resected is not possible with this type of resection. Nevertheless, hepatic surgeons are now routinely achieving comparable results with resection of smaller segments of liver as was possible in the past with major lobe resection.

Since the amount of liver to be resected can now be more precisely tailored to the extent of metastatic involvement, the possibility exists for removal of multiple lesions involving more than a single hepatic lobe. Reports of removal of as many as 13 lesions from one patient have appeared, although there are limits to the number of tumors that can be excised if each one is to have a margin of one centimeter of normal liver beyond the edge of malignant cells.

More recently, the technique of cryotherapy, freezing the metastatic lesions to kill the malignant cells within, has been pioneered at a number of university medical centers. By this technique, a probe which can be cooled by liquid nitrogen is positioned in the center of each metastatic lesion using intraoperative ultrasound to guide placement. When the tip of the probe is in proper position, liquid nitrogen is passed through it to freeze the tissue in contact with its tip. The size of the tissue volume frozen can be monitored by the ultrasound, which demonstrates a loss of echogenicity within the frozen tissue. When the margin of freezing advances beyond the edge of metastatic tumor, the freezing process is reversed. Generally, two

cycles of freezing and thawing are needed to eliminate viable cells within the metastic focus. No attempt is made to remove the frozen area, which shrinks in size over the weeks following treatment. This reduces the degree of blood loss entailed by resection of multiple scattered lesions. Data from centers experienced in the use of cryotherapy suggest that adequate ablation of lesions by this technique is equivalent to obtaining negative surgical margins in terms of its effect on long term survival. Patients appear to require less postoperative care than after major resection, although they usually experience fever for 24 to 48 hours. Current cryotherapy units contain two separate probes, so that two lesions can be frozen at the same time, shortening the overall time of the procedure. Newer developments may allow cryotherapy to be adapted for laparoscopic application, which would limit the need for open abdominal exploration in the surgical treatment of hepatic metastases.

Cryotherapy is now available as a treatment modality in Western Massachusetts. Early experience at our institution substantiates that of others in showing that multiple lesions can be ablated without blood loss requiring transfusion or prolonged periods of post-operative hospitalization. Although well adapted to multiple lesions and small foci located deep within an hepatic lobe, cryotherapy is difficult to apply with consistency to lesions located near large blood vessels which act as a heatsink to limit cooling. For these lesions, and for peripheral metastases that are easy to resect, surgical extirpation is likely to continue as the procedure of choice. ■

Physicians Frustrated And Disgusted With 3% CD's. Say They Are Victims Of Bank's Greed

Boston Ma - Today's retirees, and future retirees, who are counting on their nest eggs to provide for them, are frustrated and angry. They feel that the banks are taking advantage of the economy to create obscene profits.

A local physician was quoted as saying, "The bank is still charging people over 17% on credit card balances, while paying me a lousy 3.1% on my CD! This is unfair. I have worked hard my whole life, and just expect to be treated fairly. In the last three years, I have seen all my expenses go up, and my CD returns drop to less than half of what it was! The banks should be ashamed of themselves. I have no choice but to look elsewhere."

The feelings of this doctor seem to be universal, when people are asked about this touchy topic.

Although CD's are insured by an agency of the US Government, and alternatives may not be, people can do much better with their savings.

As with anything else, knowledge is the key. The banks are making more money than ever, and hope the average person will not bother to learn about their alternatives. The bankers want people to keep their money tied up at these disgusting low rates, and know a lot of us will not move because of the fear of the unknown.

A **FREE REPORT** called, **The Secret to Beating CD's**, has been made available for the first time. The report explains, in simple language, the steps you can take to stop being at the mercy of the banks. You can call 1-800 -776-6418, 24hours, for a Free, recorded message, to get your copy of the report. Call now, and find out what the bank doesn't want you to know!

Cancer Rehabilitation

Alfred L. McKee, M.D., is a member of the Division of Hematology/Oncology at Baystate Medical Center, and Medical Director of Oncology Rehabilitation at Rehab West.

When most people think of cancer rehabilitation, a rather standard model comes to mind. A person has undergone an amputation and is learning to live with an artificial limb; or perhaps a person has undergone treatment for spinal cord compression or a brain tumor, and requires neurologic rehabilitation. Or, perhaps a major operation resulted in severe debilitation, and some sort of aggressive recovery program is necessary to return the patient to a more functional state.

"Rehabilitation... has frequently been neglected in the cancer patient."

A common denominator in the above is the supposition that the cancer is "taken care of" for the time being, at least, and that a relatively standard rehabilitation program can be applied, sometimes lasting for several months.

These, however, comprise a minority of cases in which rehabilitation is of medical benefit. The more common situation is the patient in whom the disease and/or its treatment has resulted in a state of disability, and in which the likelihood of long-term control or cure is absent or small. Yet in these patients, restortion of more normal function, even for a relatively short period of time, can make a major difference in the quality of their remaining life.

Cancer rehabilitation, therefore, must take into account the prognosis of the patient; the stability of the clinical condition (obviously rapid deterioration is not compatible with rehabilitation), and the concurrent treatments being directed at the cancer or the symptoms of cancer. In addition, time is of the essence.

In conventional rehabilitation, patients are treated until improvement ceases, or until normal function is achieved. The treatment program is modified as time goes on to build on what has previously been accomplished. goals are set, indeed, but frequently modified as things unfold.

In general, cancer rehabilitation has to be accomplished in a finite period of time, since the patient does not have an open-ended budget of time to spend.

To this end, cancer rehabilitation is best carried out intensively, even in an inpatient setting, where a concentrated interdisciplinary approach can be rendered.

In the model which we have developed and refined, a medical oncologist works as a member of a large team, which includes a physiatrist, physical therapists, occupational therapists, speech therapists, vocational therapists, a nutritionist, a psychologist, social workers, and nurses skilled in both cancer care and rehabilitation. All parameters are identified which are impairing the function of the patient. We then determine the degree to which functional improvement can be achieved, and whether that degree of improvement will result in meaningful performance benefit for the patient. A person who is completely bedridden who can with intensive therapy be able to partially help himself move into a chair is not a candidate for this sort of rehabilitation. A bedridden patient who can become wheelchair-independent may very well be.

If the patient is accepted as a candidate for rehabilitation, he/she and his significant others are presented with the possible benefits; does the patient want to commit him/herself to achieve these often less-than-perfect objectives. If so, a short term program is developed for each of the relevant parameters, and the patient is then admitted to the rehabilitation hospital for a period generally no longer than three weeks.

During this time, several sessions a day are carried out with physical and occupational

therapists as well as other professionals as needed. The patient is reviewed by a medical oncologist at least weekly. If concurrent cancer treatment or pain management is required, this is integrated into the plan and carried out by a certified nurse oncologist working with the rest of the staff under the direction of the medical oncologist. We have successfully combined radiation therapy and chemotherapy during rehabilitation, and actually find that pain management in this setting can allow for more responsive and rational analgesic adjustments.

Another new area that we have been developing is the rehabilitation of cancer patients in the post operative period. While traditionally this was limited to brain tumor patients, the rehab setting can be the best setting for recovering from exhaustive anticancer surgery as soon as that patient is stable. Selected patients status post thoracic surgery or abdominal surgeries, total pelvic exenteration, and particularly patients recovering from head and neck surgery. Our team has expertise in speech therapy, tracheostomy care, and the special nutritional needs of this group of patients as well as experience with ostomy care and other nursing/rehab issues surrounding wound care.

Each patient is carefully reviewed by the whole team on a weekly basis; this review is most helpful in further refining the paradigm we use for providing rehabilitation services to our patients.

It became apparent early on that, while inpatient rehabiliation had several theoretical advantages, it was simply not feasible for, and often not desired by, many of our potential patients. At present we are working on a "day stay" model which would hopefully preserve several of the benefits of the inpatient model, while allowing the patient to be home more of the time.

The treatment of the "incurable" cancer patient has traditionally been directed at the tumor, since tumor regression is the best palliation. When this failed, therapy was directed towards symptom control. While both are laudable goals, it is important now to consider another dimension of therapy—the short-term, limited, but very meaningful improvement in function, which heretofore has frequently been neglected in the managment of the cancer patient. ■

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Omar Pace:

The Changing Face of Cancer Care

Omar Pace graduated from the University of Iowa with an M.D. in 1943. After general surgical training at the University of Louisville and the Franklin Square Hospital, he came to the Pioneer Valley to be a surgical resident at the State Cancer Hospital in Westfield in 1946 (now the Western Massachusetts Hospital). He has subsequently served as Chief of Staff and Chief Surgeon at Westfield from 1958 to 1972. He has also been part time director of surgical oncology at Springfield Hospital (now Baystate Medical Center) from 1971 until 1988 while maintaining a practice in general surgery in Springfield. He was president of the Massachusetts division of the American Cancer Society from 1970-1972 and a delegate to the National ACS from 1973 to 1989. He continues as a director of the Massachusetts Division of the ACS today. He talked to the **Hippocrat** *recently about his perspective on the treatment of cancer in the Pioneer Valley over the past fifty years.*

Q What can you tell us about the earliest formal treatment of cancer in our area?

A Dr. Frederick S. Hopkins (the grandfather of HDMS member Dr. John Griggs) was also the "granddaddy" of cancer care locally. He arranged for a week of cancer screening and diagnosis locally in November, 1921. The American Cancer Society had just been started in 1913. In February, 1926, Dr. Hopkins established a rotation of free cancer clinics weekly between the Springfield Mercy and Wesson Memorial Hospitals. These were combined in 1935 by Dr. John E. Dwyer with the Springfield Hospital as the site and the medical staffs rotating coverage.

Q How was the cancer hospital at Westfield founded?

A The state of Massachusetts designated fifty beds for cancer care at the existing state T.B. Sanatorium in Westfield in 1937. For the next thirty-five years, the State Cancer Hospital at Westfield was without a doubt the main focus of cancer care in western Massachusetts. Dr. Ernest Daland of Boston was the first Chief Surgeon and Chief of Staff followed by Dr. Hopkins from 1939 to 1957.

Q What was the educational role of the hospital at Westfield?

A Starting in 1940, the State Cancer Hospital had the only board approved program for surgical training in the state outside of Boston. Over the next thirty years, there were approximately 100 surgical board eligible graduates. Twenty of these stayed in the Springfield area and formed a nucleus of continuing good cancer care. In the 1950s, Westfield also developed an approved training program in pathology and in radiation therapy.

Q How was the care organized at the hospital?

A Wednesday was the big clinic day. An exellent staff conference was held after the patients were seen. Any problem or unusual case was presented by the residents. All patients who were to have treatment (surgical, radiation or medical) during the coming week were discussed. For a major unusual case, the patient was brought in for the doctors to question and examine. For a long clinic day or a 12 hour operation, the state reimbursed the physician at the same rate: twenty five dollars for that "visit" to the hospital.

Q What services were uniquely available at Westfield?

A The medical and nursing staffs were outstanding. There were consultants from Boston on a regular monthly schedule. Some included Drs. Joe Meigs and Howard Ulfelder in gynecology who taught us to do radical hysterectomies and pelvic exenterations in the late 1940s. Dr. Tom Hall supervised our chemotherapy in its infancy. For years, Westfield had the only x-ray therapy machine outside of Boston and gave most of the radiation therapy in the Valley, especially for cancer of the cervix and uterus. Surgeries included Whipple operations, pneumonectomies, craniotomies, nephrectomies and radical facial and neck resections. Locally, Westfield drew on all the specialists from Springfield, Northampton, Pittsfield and Greenfield and people like Drs. Al Palemermo, Don Hayes, John Tate, Eugene Beauchamp, James Seaman, Bernie Bloom, Joe Hahn, Fred Post, Ed Manuell, Bill Davis, Archie Douglas and Irving Meyer were involved. Westfield did the only Pap smears in the area for the first five years after the discover of the technique in 1942.

Q What political changes led to the decline of the cancer service at Westfield?

A The advent of Medicare in 1965 gradually changed the whole pattern of cancer care. The Westfield patients had been mostly elderly people with major problems. Now they had insurance to pay for hospitals and doctors. There was a nucleus of well trained doctors in Springfield interested in cancer care; many of them had trained at Westfield.

In 1969, the Kellogg Foundation surveyed 22 cities regarding their health needs as a pioneering effort in modern health planning. Springfield was one of the cities chosen to be surveyed and the Western Massachusetts Health Planning Council was founded. Some coordination of the efforts between the Springfield Hospital and the State Cancer Hospital at Westfield was proposed. The Springfield Hospital decided thay did not want to get involved with State but they then upgraded their own cancer programs.

Q What further changes took place in the 1970s?

A I formed the Cancer Group of Western Massachusetts in 1970 with a representative of each of the Valley hospitals to promote good cancer care and to advise the public and the politicians. The federal government subsequently designated twenty six cancer centers throughout the country. After much closed door maneuvering, the yet to be built Sidney Farber Comprehensive Cancer Center was designated as the New England cancer center. An outreach group was started in 1972 and first directed by Dr. Isaac Lewin. This program later lost its funding in 1978.

Q What are your thoughts on the changes that have taken place in cancer care during your time in practice?

A When I first started at the Cancer hospital in 1946, we were curing 10% of childhood cancers; the cure rate is now 75%. Breast cancer cures were about 50%; now the rate is 80-90% if found early. In Hodgkin's disease and cancer of the testis if metastases developed all the patients died, now 70% can be cured. In 1946, 500,000 people got cancer now it is 1 million, yet 500,000 people still die of cancer every year. Smoking kills 150,000 a year. I founded the Springfield unit of the American Cancer Society in 1949 with Dr. Hopkins and a retired minister Arthur Rudman. Today the unit has 15 standing committees with 100 volunteers.

The future of cancer lies in genetic engineering. The ability to identify and cut out a single gene from the millions on our DNA chain and replace it with a modified or a new gene will spell the answer I believe. It is an exciting era for future doctors and researchers to unravel the mysteries of life itself. ■

Brigid K. Glackin, M.D.

"Smoke-Free Class of 2002 Poster Contest"

Pictured on our cover is the Hampden County Grand Prize Winner of the Third Annual "Smoke-Free Class of 2002 Poster Contest." The final judging took place on Monday, May 3 at the Holyoke Mall where the posters were on display for two weeks. This winning entry was created by Sarah Derby, a third grade student at the Center Elementary School in Longmeadow. A $200 Savings Bond was presented to Ms. Derby by Hampden District Medical Society President Robert V. Chircop, M.D. during an Awards Ceremony and Reception on May 12th at Springfield Symphony Hall. Dr. David Jackson, President of the Hampshire District Medical Society presented the Hampshire County Grand Prize to Billy Cruz, a third grade student at the Robert K. Finn Elementary School in Northampton. Over 5,000 third grade students participated in the poster contest which was expanded this year to include all towns in Hampden and Hampshire Counties. All participating students received McDonald's Gift Certificates. All runner-up entrants received a one day pass to Riverside Park. One First Place Winner in each of the seventy-five schools received a $50 Savings Bond, and all runner-up and First Place Winners also received a certificate of recognition signed by United States Senator Edward M. Kennedy. The contest was underwritten by a grant from Marion Merrell Dow, Inc. with additional help from the Massachusetts Mutual Life Insurance Company, the Hampden District Medical Society Ladies Auxiliary, Riverside Park, and McDonald's owner operators. ■

Hil and Billy

Hil and Billy were vacationing in Arkansas. They pulled into a rural gas station. Hil went in for a long time. When she came out, Billy asked, "What took you so long?" Hil replied, "Oh, that was just an old boyfriend of mine."

Billy laughed. "If you had married him, you'd be the wife of a gas station attendant!"

"No, Billy," replied Hil. "I'd be the wife of the President of the United States."

Hil and Billy and Al Gore got wiped out in a Bus accident. They approached the throne of God. "Al," said God, "you've done good. Take this seat on my left hand." Billy came along. "Billy," said God, "You've really tried. You deserve a reward. Take the seat on my right hand." Just then, Hil showed up. She looked the Almighty square in the eye, and said, "that's my seat you're sitting in, Buster!"

It's not uncommon for a new president to lose popularity early on. Billy was no exception. What no one could figure out was why Hil was gaining in popularity. Finally after numerous polls and focus groups, they found out. It's because anyone who quits being a lawyer is bound to become more popular! ■

Submitted by Robert Dole, M.D.

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New Members Welcome

Roberto Arce, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 2, 1956
Premed: Miami-Dade Community College, Florida 1974-1976
University of Miami, Florida 1976-1978
Medical: University of Miami School of Medicine, Florida 1978-1982
Internship: University of Miami-Jackson Memorial Hospital 1982-1983
Residency: University of Miami-Jackson Memorial Hospital 1983-1985
Fellowship: Henry Ford Hospital, Detroit, Michigan 1989-1992
Baystate Medical Center 1992-Present
Specialty: Internal Medicine/Cardiology
Fellow

Presio A. Ballista, M.D.
37 Main Street
Belchertown, MA 01007

Born: February 19, 1939
Premed: Autonomous University of Santa Domingo, Dominican Republic 1956-1962
Internship: Mount Vernon Hospital, New York 1969-1970
Residency: Bronx-Lebanon Hospital, New York 1970-1972
Specialty: Pediatrics

Scott R. Cooper, M.D.
77 Winsor Street #301
Ludlow, MA 01056

Born: October 1, 1962
Premed: Cornell University, New York 1984
Medical: State University of New York, Stoneybrook 1988
Internship: Baystate Medical Center 1988-1989
Residency: New York University Medical Center 1989-1992
Specialty: Physical Medicine and Rehabilitation

Anthony Acquista, M.D.
Wing Memorial Hospital
Wright Street
Palmer, MA 01069

Born: June 26, 1949
Premed: Fordham University, New York 1966-1970
Medical: University of Bologna School of Medicine, Italy 1970-1977
Internship: Lutheran Medical Center, New York 1977-1978
Residency: Lutheran Medical Center, New York 1978-1980
Specialty: Internal Medicine

Arthur G. King, Jr., M.D.
49 Southwick Road
Westfield, MA 01085

Born: June 3, 1949
Premed: LaSalle College, Pennsylvania 1968-1969
University of Connecticut 1971-1974
Medical: University of Connecticut School of Medicine 1975-1979
Internship: University of Rochester Medical Center 1979-1980
Residency: University of Rochester Medical Center 1980-1982
Specialty: Internal Medicine

Rhett D. Krause, M.D.
Mercy Hospital Radiology Dept.
271 Carew Street
Springfield, MA 01104

Born: April 8, 1959
Premed: Amherst College, MA 1977-1981
Medical: University of Connecticut 1982-1986
Internship: St. Francis Hospital, CT 1986-1987
Residency: Lahey Clinic, MA 1987-1991
Fellowship: New England Medical Center 1991-1992
Specialty: Radiology

Continued on next page

New Members Welcome

Continued from previous page

Gregory J. Faust, M.D.
300 Stafford Street
Springfield, MA 01104

Born: March 16, 1961
Premed: University of Rochester, New York 1978-1979
University of Pennsylvania, 1979-1982
Medical: Cornell University Medical College 1982-1986
Internship: The Graduate Hospital 1986-1987
Residency: The New York Hospital/Cornell Medical Center 1987-1990
Specialty: Ophthalmology

Stanley M. Polansky, M.D.
Radiology and Imaging, Inc.
P.O. Box 2250
Springfield, MA 01101

Born: April 3, 1950
Premed: City University of New York, Brooklyn College 1966-1970
Medical: State University of New York-Upstate Medical Center 1970-1974
Internship: Yale-New Haven Hospital, CT 1974-1975 Internal Medicine/ Radiology
Residency: Yale-New Haven Hospital, CT 1975-1978 Diagnostic Radiology
Fellowship: Hospital for Sick Children, Toronto, Canada 1978-1979 Pediatric Radiology
Specialty: Diagnostic Radiology/Pediatric Radiology

Michael Prefontaine, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: April 30, 1955
Premed: College Lionel-Grouix, Ste. Therese, Canada 1971-1973
Medical: University of Montreal, Canada 1973-1978
Internship: St. Mary's Hospital/Affiliate of McGill University Montreal, Canada 1978-1979
Residency: McGill University Affiliated Hospital, Canada 1979-1983
Fellowship: McMaster University, Hamilton, Ontario/University of Toronto, Ontario, Canada 1983-1985
Specialty: Obstetrics/Gynecology/Gynecological Oncology

Karen L. Scruggs, M.D.
39 Horseshoe Circle
Ware, MA 01082

Born: May 14, 1947
Medical: Washington University School of Medicine 1968-1973
Internship: Massachusetts General Hospital, Boston 1973-1974
Residency: Massachusetts General Hospital 1974-1975
Fellowship: St. Louis Children's Hospital 1975-1976
Specialty: Pediatrics/Adolescent Medicine

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